Complete Summary

GUIDELINE TITLE

Screening for obesity in children and adolescents: U.S. Preventive Services Task Force recommendation statement.

BIBLIOGRAPHIC SOURCE(S)

US Preventive Services Task Force. Screening for obesity in children and adolescents: US Preventive Services Task Force recommendation statement. Pediatrics 2010 Feb;125(2):361-7. PubMed

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: U.S. Preventive Services Task Force (USPSTF). Screening and interventions for overweight in children and adolescents: recommendation statement. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2005. 11 p.

** REGULATORY ALERT **

FDA WARNING/REGULATORY ALERT

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

- January 21, 2010 - Meridia (sibutramine hydrochloride): The U.S. Food and Drug Administration (FDA) notified healthcare professionals that the review of additional data indicates an increased risk of heart attack and stroke in patients with a history of cardiovascular disease using sibutramine. Based on the serious nature of the review findings, FDA requested and the manufacturer agreed to add a new contraindication to the sibutramine drug label stating that sibutramine is not to be used in patients with a history of cardiovascular disease.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Obesity

Note: Obesity is defined as an age- and gender-specific body mass index (BMI) at ≥95th percentile.

GUIDELINE CATEGORY

Prevention
Screening

CLINICAL SPECIALTY

Family Practice
Pediatrics
Preventive Medicine
Psychiatry
Psychology

INTENDED USERS

Advanced Practice Nurses
Health Care Providers
Health Plans
Managed Care Organizations
Nurses
Physician Assistants
Physicians
Psychologists/Non-physician Behavioral Health Clinicians

GUIDELINE OBJECTIVE(S)

- To summarize the current U.S. Preventive Services Task Force (USPSTF) recommendations and supporting scientific evidence on screening for obesity in children and adolescents
- To update the 2005 USPSTF recommendations on screening for overweight in children and adolescents

TARGET POPULATION

Children and adolescents aged 6 to 18 years seen in primary care

INTERVENTIONS AND PRACTICES CONSIDERED

1. Screening for obesity in children and adolescents using body mass index (BMI)
2. Referral to comprehensive, intensive behavioral interventions

MAJOR OUTCOMES CONSIDERED

Key Question 1: Do weight-management programs (behavioral, pharmacological) lead to body mass index (BMI), weight, or adiposity stabilization or reduction in children and adolescents who are obese ($\geq$ 95th BMI percentile) or overweight (85th to 94th percentile)?

Key Question 1a: Do these programs lead to other positive outcomes (e.g., improved behavioral or physiologic measures, decreased childhood morbidity, improved childhood functioning, or reduced adult morbidity and mortality)?

Key Question 1b: Do specific components of the programs influence the effectiveness of the programs?

Key Question 1c: Are there population or environmental factors that influence the effectiveness of the programs?

Key Question 2: Do weight-management programs (behavioral, pharmacological) help children and adolescents who were initially obese or overweight maintain BMI, weight, or adiposity improvements after the completion of an active intervention?

Key Question 2a: Do these programs lead to other positive outcomes (e.g., improved behavioral or physiologic measures, decreased childhood morbidity, improved childhood functioning, or reduced adult morbidity and mortality)?

Key Question 2b: Do specific components of the programs influence the effectiveness of the programs?

Key Question 2c: Are there population or environmental factors that influence the effectiveness of the programs?

Key Question 3: What are the adverse effects of weight-management programs (behavioral, pharmacological) attempting to stabilize, reduce, or maintain BMI?

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): A systematic evidence review update was prepared by the Oregon Evidence-based Practice Center (EPC) for use by the U.S. Preventive Services Task Force (USPSTF) (see the "Availability of Companion Documents" field).

EPC staff based the updated literature searches on the previous USPSTF review and intervening systematic reviews from the National Institute for Health and Clinical Excellence (NICE) and the Agency for Healthcare Research and Quality (AHRQ). Staff searched Ovid Medline, PsycINFO, the Database of Abstracts of Reviews of Effects, the Cochrane Database of Systematic Reviews, the Cochrane Central Register of Controlled Trials, and the Education Resources Information Center from 2005 (2003 for pharmacologic treatments) to June 10, 2008, to identify literature that was published after the search dates of these reports (Appendices 1 and 2 of the targeted systematic review [see "Availability of Companion Documents" field]). Besides examining trials from key previous systematic reviews, EPC staff hand-searched the reference lists of other good-quality reviews of childhood obesity treatment, of all included trials, and further supplemented with expert-identified studies. Staff did not examine non–peer-reviewed sources (gray literature) or non–English-language literature.

Two investigators independently reviewed 2786 abstracts and 369 articles against inclusion and exclusion criteria prespecified for each key question (Appendix 3 of the targeted systematic review [see "Availability of Companion Documents" field]). Discrepancies were resolved by consensus.

NUMBER OF SOURCE DOCUMENTS

- Articles included for behavioral interventions: 15 studies in 18 articles
- Articles included for pharmacologic interventions: 10 studies in 12 articles

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Meta-Analysis
Review of Published Meta-Analyses
Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): A systematic evidence review update was prepared by the Oregon Evidence-based Practice Center (EPC) for use by the U.S. Preventive Services Task Force (USPSTF) (see the "Availability of Companion Documents" field).

One investigator abstracted prespecified study information (Appendix 4 of the targeted systematic review [see "Availability of Companion Documents" field]) into evidence tables, and a second investigator verified the accuracy. Two investigators independently quality rated the studies by using design-specific criteria (see Appendix 5 of the targeted systematic review). Discrepancies were resolved by consensus or consultation with a third investigator. Poor-quality studies were excluded.

Among behavioral trials, hours of contact was calculated as a proxy for treatment intensity and categorized as very low (<10 hours), low (10 to 25 hours), moderate (26 to 75 hours), or high (>75 hours). Weight outcomes were categorized as short-term (6 to 12 months since beginning treatment) or maintenance (between 1 and 4 years after beginning treatment and at least 12 months after ending active treatment). Interventions were considered comprehensive if they included (1) weight loss or healthy diet counseling, (2) physical activity counseling or physical activity program participation, and (3) behavioral management techniques to help make and sustain changes in diet and physical activity.

When possible, data were synthesized by using quantitative methods. For many questions, however, investigators relied on qualitative synthesis because of significant heterogeneity in setting, age range, intervention approach, weight or other outcome reported, and length of follow-up. For the behavioral interventions, meta-analyses of short-term and maintenance outcomes were conducted separately. Investigators performed a statistical test of heterogeneity (I^2), which measures the percentage of variability in effect size attributable to between-study variation (as opposed to within-study sampling error). Values of <30% were considered to indicate little heterogeneity and those of >50% to indicate possible substantial heterogeneity incompatible with pooling. Funnel plots to assess for publication bias were not conducted, because the data were too heterogeneous to combine or, when pooled, included no more than 3 studies. EPC investigators used change in body mass index (BMI) from baseline as the preferred measure of weight change when it was available. If BMI change was unavailable and could not be calculated or obtained from the author, change in BMI standard deviation score (SDS) was used as the second choice and change in percent overweight as the third choice. Because investigators combined different outcomes, they analyzed standardized effect sizes. As a sensitivity analysis, they also ran meta-analyses to examine only those that reported BMI change. All meta-analyses were conducted by using RevMan 4.2 (Copenhagen: The Nordic Cochrane Center, The Cochrane Collection). Additional details, including assumptions for modeling BMI change at various ages, are reported in Appendix 1 of the targeted systematic review (see "Availability of Companion Documents" field).

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Balance Sheets
Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The U.S. Preventive Services Task Force (USPSTF) systematically reviews the evidence concerning both the benefits and harms of widespread implementation of a preventive service. It then assesses the certainty of the evidence and the magnitude of the benefits and harms. On the basis of this assessment, the USPSTF assigns a letter grade to each preventive service signifying its recommendation about provision of the service (see Table below). An important, but often challenging, step is determining the balance between benefits and harms to estimate "net benefit" (that is, benefits minus harms).

Table 1. U.S. Preventive Services Task Force Recommendation Grid*

Certainty of Net Benefit	**Magnitude of Net Benefit**			
	Substantial	**Moderate**	**Small**	**Zero/Negative**
High	A	B	C	D
Moderate	B	B	C	D
Low	Insufficient			

**A*, *B*, *C*, *D*, and *I (Insufficient)* represent the letter grades of recommendation or statement of insufficient evidence assigned by the U.S. Preventive Services Task Force after assessing certainty and magnitude of net benefit of the service (see the "Rating Scheme for the Strength of the Recommendations" field).

The overarching question that the USPSTF seeks to answer for every preventive service is whether evidence suggests that provision of the service would improve health outcomes if implemented in a general primary care population. For screening topics, this standard could be met by a large randomized, controlled trial (RCT) in a representative asymptomatic population with follow-up of all members of both the group "invited for screening" and the group "not invited for screening."

Direct RCT evidence about screening is often unavailable, so the USPSTF considers indirect evidence. To guide its selection of indirect evidence, the USPSTF constructs a "chain of evidence" within an analytic framework. For each key question, the body of pertinent literature is critically appraised, focusing on the following 6 questions:

1. Do the studies have the appropriate research design to answer the key question(s)?
2. To what extent are the existing studies of high quality? (i.e., what is the internal validity?)
3. To what extent are the results of the studies generalizable to the general U.S. primary care population and situation? (i.e., what is the external validity?)
4. How many studies have been conducted that address the key question(s)? How large are the studies? (i.e., what is the precision of the evidence?)
5. How consistent are the results of the studies?
6. Are there additional factors that assist the USPSTF in drawing conclusions (e.g., presence or absence of dose–response effects, fit within a biologic model)?

The next step in the process is to use the evidence from the key questions to assess whether there would be net benefit if the service were implemented. In 2001, the USPSTF published an article that documented its systematic processes

of evidence evaluation and recommendation development. At that time, the USPSTF's overall assessment of evidence was described as good, fair, or poor. The USPSTF realized that this rating seemed to apply only to how well studies were conducted and did not fully capture all of the issues that go into an overall assessment of the evidence about net benefit. To avoid confusion, the USPSTF has changed its terminology. Whereas individual study quality will continue to be characterized as good, fair, or poor, the term *certainty* will now be used to describe the USPSTF's assessment of the overall body of evidence about net benefit of a preventive service and the likelihood that the assessment is correct. Certainty will be determined by considering all 6 questions listed above; the judgment about certainty will be described as high, moderate, or low.

In making its assessment of certainty about net benefit, the evaluation of the evidence from each key question plays a primary role. It is important to note that the USPSTF makes recommendations for real-world medical practice in the United States and must determine to what extent the evidence for each key question—even evidence from screening RCTs or treatment RCTs—can be applied to the general primary care population. Frequently, studies are conducted in highly selected populations under special conditions. The USPSTF must consider differences between the general primary care population and the populations studied in RCTs and make judgments about the likelihood of observing the same effect in actual practice.

It is also important to note that one of the key questions in the analytic framework refers to the potential harms of the preventive service. The USPSTF considers the evidence about the benefits and harms of preventive services separately and equally. Data about harms are often obtained from observational studies because harms observed in RCTs may not be representative of those found in usual practice and because some harms are not completely measured and reported in RCTs.

Putting the body of evidence for all key questions together as a chain, the USPSTF assesses the certainty of net benefit of a preventive service by asking the 6 major questions listed above. The USPSTF would rate a body of convincing evidence about the benefits of a service that, for example, derives from several RCTs of screening in which the estimate of benefits can be generalized to the general primary care population as "high" certainty (see the "Rating Scheme for the Strength of Recommendations" field). The USPSTF would rate a body of evidence that was not clearly applicable to general practice or has other defects in quality, research design, or consistency of studies as "moderate" certainty. Certainty is "low" when, for example, there are gaps in the evidence linking parts of the analytic framework, when evidence to determine the harms of treatment is unavailable, or when evidence about the benefits of treatment is insufficient. Table 4 in the methodology document listed below (see "Availability of Companion Documents" field) summarizes the current terminology used by the USPSTF to describe the critical assessment of evidence at all 3 levels: individual studies, key questions, and overall certainty of net benefit of the preventive service.

Sawaya GF et al. Update on the methods of the U.S. Preventive Services Task Force: estimating certainty and magnitude of net benefit. Ann Intern Med. 2007;147:871-875 [5 references].

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

What the U.S. Preventive Services Task Force (USPSTF) Grades Mean and Suggestions for Practice

Grade	Grade Definitions	Suggestions for Practice
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer or provide this service.
B	The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.	Offer or provide this service.
C	The USPSTF recommends against routinely providing the service. There may be considerations that support providing the service in an individual patient. There is moderate or high certainty that the net benefit is small.	Offer or provide this service only if other considerations support offering or providing the service in an individual patient.
D	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.	Discourage the use of this service.
I Statement	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.	Read "Clinical Considerations" section of USPSTF Recommendation Statement (see "Major Recommendations" field). If this service is offered, patients should understand the uncertainty about the balance of benefits and harms.

USPSTF Levels of Certainty Regarding Net Benefit

Definition: The USPSTF defines certainty as "likelihood that the USPSTF assessment of the net benefit of a preventive service is correct." The net benefit is defined as benefit minus harm of the preventive service as implemented in a general, primary care population. The USPSTF assigns a certainty level based on the nature of the overall evidence available to assess the net benefit of a preventive service.

Level of Certainty	Description
High	The available evidence usually includes consistent results from well-designed, well-conducted studies in representative primary care populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly

Level of Certainty	Description
	affected by the results of future studies.
Moderate	The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by factors such as: • The number, size, or quality of individual studies • Inconsistency of findings across individual studies • Limited generalizability of findings to routine primary care practice • Lack of coherence in the chain of evidence As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion.
Low	The available evidence is insufficient to assess effects on health outcomes. Evidence is insufficient because of: • The limited number or size of studies • Important flaws in study design or methods • Inconsistency of findings across individual studies • Gaps in the chain of evidence • Findings not generalizable to routine primary care practice • A lack of information on important health outcomes More information may allow an estimation of effects on health outcomes.

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Comparison with Guidelines from Other Groups
External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Peer Review. Before the U.S. Preventive Services Task Force (USPSTF) makes its final determinations about recommendations on a given preventive service, the Evidence-based Practice Center and the Agency for Healthcare Research and Quality send a draft evidence review to 4 to 6 external experts and to Federal agencies and professional and disease-based health organizations with interests in the topic. The experts are asked to examine the review critically for accuracy and completeness and to respond to a series of specific questions about the document. After assembling these external review comments and documenting the proposed response to key comments, the topic team presents this information to the USPSTF in memo form. In this way, the USPSTF can consider these

external comments before it votes on its recommendations about the service. Draft recommendation statements are then circulated for comment from reviewers representing professional societies, voluntary organizations, and Federal agencies. These comments are discussed before the final recommendations are confirmed.

Comparison with Guidelines from Other Groups. Recommendations for screening for obesity in children and adolescents were considered from the following groups: the American Medical Association (AMA) and the American Academy of Pediatrics (AAP).

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The U.S. Preventive Services Task Force (USPSTF) grades its recommendations (A, B, C, D, or I) and identifies the levels of certainty regarding net benefit (High, Moderate, and Low). The definitions of these grades can be found at the end of the "Major Recommendations" field.

Summary of Recommendations and Evidence

The USPSTF recommends that clinicians screen children aged 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status. **This is a grade B recommendation**.

Clinical Considerations

Patient Population Under Consideration

This recommendation applies to children and adolescents aged 6 to 18 years. The USPSTF is using the following terms to define categories of increased body mass index (BMI): overweight is defined as an age- and gender-specific BMI between the 85th and 95th percentiles, and obesity is defined as an age- and gender-specific BMI at $\geq$95th percentile. The USPSTF did not find sufficient evidence for screening children younger than 6 years.

Screening Tests

In 2005, the USPSTF found adequate evidence that BMI was an acceptable measure for identifying children and adolescents with excess weight. BMI is calculated from the measured weight and height of an individual.

Treatment

The USPSTF found that effective comprehensive weight-management programs incorporated counseling and other interventions that targeted diet and physical activity. Interventions also included behavioral management techniques to assist in behavior change. Interventions that focused on younger children incorporated

parental involvement as a component. Moderate- to high-intensity programs involved >25 hours of contact with the child and/or the family over a 6-month period and showed results including improved weight status, defined as an absolute and/or relative decrease in the BMI 12 months after the beginning of the intervention. Most participants were obese, and it is not known whether these results can be applied to children who are overweight but not obese. In addition, evidence was limited on the long-term sustainability of BMI changes achieved through behavioral interventions and on the trajectory of weight gain in children and adolescents. Interventions generally took place in referral settings, and the results can only be generalized to children who follow through on treatment. Low-intensity interventions, defined as ≤25 contact hours over a 6-month period, did not result in significant improvement in weight status.

Interventions that combined pharmacologic agents (sibutramine or orlistat) with behavioral interventions resulted in modest short-term improvement in weight status in children aged 12 years and older. There were no long-term data on the maintenance of improvement after discontinuation of medications. The magnitude of the harms of these drugs in children could not be estimated with certainty. Adverse effects included elevated heart rate, elevated blood pressure, and adverse gastrointestinal effects. Sibutramine, a centrally acting appetite suppressant, has been approved by the US Food and Drug Administration (FDA) for use in adolescents aged 16 years and older. Orlistat, a lipase inhibitor, has been approved by the FDA for use in adolescents aged 12 years and older. Neither sibutramine nor orlistat has been approved for use in pediatric populations younger than 12 years.

Screening Intervals

No evidence was found regarding appropriate intervals for screening. Height and weight, from which BMI is calculated, are routinely measured during health maintenance visits.

Definitions:

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	individual patient. There is moderate or high certainty that the net benefit is small.	
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Low	The available evidence is insufficient to assess effects on health outcomes. Evidence is insufficient because of: • The limited number or size of studies

Level of Certainty	Description
	• Important flaws in study design or methods • Inconsistency of findings across individual studies • Gaps in the chain of evidence • Findings not generalizable to routine primary care practice • A lack of information on important health outcomes More information may allow an estimation of effects on health outcomes.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is not specifically stated for each recommendation.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Benefits of Detection and Early Intervention/Treatment

The U.S. Preventive Services Task Force (USPSTF) found adequate evidence that multi-component, moderate- to high-intensity behavioral interventions for obese children and adolescents aged 6 years and older can effectively yield short-term (up to 12 months) improvements in weight status. Inadequate evidence was found regarding the effectiveness of low-intensity interventions.

POTENTIAL HARMS

Harms of Detection and Early Intervention/Treatment

There is adequate evidence that the harms of behavioral interventions are no greater than small.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- The U.S. Preventive Services Task Force (USPSTF) makes recommendations about preventive care services for patients without recognized signs or symptoms of the target condition.
- Recommendations are based on a systematic review of the evidence of the benefits and harms and an assessment of the net benefit of the service.

- The USPSTF recognizes that clinical or policy decisions involve more considerations than this body of evidence alone. Clinicians and policy makers should understand the evidence but individualize decision-making to the specific patient or situation.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The experiences of the first and second U.S. Preventive Services Task Force (USPSTF), as well as that of other evidence-based guideline efforts, have highlighted the importance of identifying effective ways to implement clinical recommendations. Practice guidelines are relatively weak tools for changing clinical practice when used in isolation. To effect change, guidelines must be coupled with strategies to improve their acceptance and feasibility. Such strategies include enlisting the support of local opinion leaders, using reminder systems for clinicians and patients, adopting standing orders, and audit and feedback of information to clinicians about their compliance with recommended practice.

In the case of preventive services guidelines, implementation needs to go beyond traditional dissemination and promotion efforts to recognize the added patient and clinician barriers that affect preventive care. These include clinicians' ambivalence about whether preventive medicine is part of their job, the psychological and practical challenges that patients face in changing behaviors, lack of access to health care or of insurance coverage for preventive services for some patients, competing pressures within the context of shorter office visits, and the lack of organized systems in most practices to ensure the delivery of recommended preventive care.

Dissemination strategies have changed dramatically in this age of electronic information. While recognizing the continuing value of journals and other print formats for dissemination, the Agency for Healthcare Research and Quality will make all USPSTF products available through its Web site. The combination of electronic access and extensive material in the public domain should make it easier for a broad audience of users to access USPSTF materials and adapt them for their local needs. Online access to USPSTF products also opens up new possibilities for the appearance of the annual, pocket-size *Guide to Clinical Preventive Services*.

To be successful, approaches for implementing prevention have to be tailored to the local level and deal with the specific barriers at a given site, typically requiring the redesign of systems of care. Such a systems approach to prevention has had notable success in established staff-model health maintenance organizations, by addressing organization of care, emphasizing a philosophy of prevention, and altering the training and incentives for clinicians. Staff-model plans also benefit from integrated information systems that can track the use of needed services and generate automatic reminders aimed at patients and clinicians, some of the most consistently successful interventions. Information systems remain a major challenge for individual clinicians' offices, however, as well as for looser affiliations of practices in network-model managed care and independent practice

associations, where data on patient visits, referrals, and test results are not always centralized.

IMPLEMENTATION TOOLS

Foreign Language Translations
Patient Resources
Personal Digital Assistant (PDA) Downloads
Pocket Guide/Reference Cards

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

US Preventive Services Task Force. Screening for obesity in children and adolescents: US Preventive Services Task Force recommendation statement. Pediatrics 2010 Feb;125(2):361-7. PubMed

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2005 Jul (revised 2010 Feb)

GUIDELINE DEVELOPER(S)

U.S. Preventive Services Task Force - Independent Expert Panel

GUIDELINE DEVELOPER COMMENT

The U.S. Preventive Services Task Force (USPSTF) is a federally-appointed panel of independent experts. Conclusions of the USPSTF do not necessarily reflect

policy of the U.S. Department of Health and Human Services (DHHS) or its agencies.

SOURCE(S) OF FUNDING

United States Government

GUIDELINE COMMITTEE

U.S. Preventive Services Task Force (USPSTF)

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

*Task Force Members**: Ned Calonge, MD, MPH, *Chair*, USPSTF (Colorado Department of Public Health and Environment, Denver, Colorado); Diana B. Petitti, MD, MPH, *Vice-chair*, USPSTF (Arizona State University, Phoenix, Arizona); Thomas G. DeWitt, MD (Children's Hospital Medical Center, Cincinnati, Ohio); Allen Dietrich, MD (Dartmouth Medical School, Lebanon, New Hampshire); Kimberly D. Gregory, MD, MPH (Cedars-Sinai Medical Center, Los Angeles, California); David Grossman, MD, MPH (Group Health Cooperative, Seattle, Washington); George Isham, MD, MS (HealthPartners, Inc., Minneapolis, Minnesota); Michael L. LeFevre, MD, MSPH (University of Missouri School of Medicine, Columbia, Missouri); Rosanne Leipzig, MD, PhD (Mount Sinai School of Medicine, New York, New York); Lucy N. Marion, PhD, RN (Medical College of Georgia, Augusta, Georgia); Bernadette Melnyk, PhD, RN (Arizona State University College of Nursing and Healthcare Innovation, Phoenix, Arizona); Virginia A. Moyer, MD, MPH (Baylor College of Medicine, Houston, Texas); Judith K. Ockene, PhD, MEd (University of Massachusetts Medical School, Worcester, Massachusetts); George F. Sawaya, MD (University of California, San Francisco, San Francisco, California); J. Sanford Schwartz, MD (University of Pennsylvania School of Medicine and The Wharton School, Philadelphia, Pennsylvania); and Timothy Wilt, MD, MPH (Minneapolis Veterans Affairs Medical Center for Chronic Disease Outcomes Research, Minneapolis, Minnesota).

**Members of the USPSTF at the time this recommendation was finalized. For a list of current USPSTF members, go to www.ahrq.gov/clinic/uspstfab.htm*.

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

The U.S. Preventive Services Task Force (USPSTF) has an explicit policy concerning conflict of interest. All members disclose at each meeting if they have a significant financial, professional/business, or intellectual conflict for each topic being discussed. USPSTF members with conflicts may be recused from discussing or voting on recommendations about the topic in question.

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: U.S. Preventive Services Task Force (USPSTF). Screening and interventions for overweight in children and

adolescents: recommendation statement. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2005. 11 p.

GUIDELINE AVAILABILITY

Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site and the Pediatrics Web site.

Print copies: Available from the Agency for Healthcare Research and Quality Publications Clearinghouse. For more information, go to http://www.ahrq.gov/news/pubsix.htm or call 1-800-358-9295 (U.S. only).

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Whitlock EP, O'Connor EA, Williams SB, Beil TL, Lutz KW. Effectiveness of primary care interventions for weight management in children and adolescents: an updated, targeted systematic review for the USPSTF. Evidence Synthesis No. 76. AHRQ Publication No. 10-05144-EF-1. Rockville, Maryland: Agency for Healthcare Research and Quality; 2010 Jan. Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site.
- Whitlock EP, O'Connor EA, Williams SB, Beil TL, Lutz KW. Effectiveness of weight management interventions in children: a targeted systematic review for the USPSTF. Pediatrics 2010; 125:e396-e418. Electronic copies: Available from the Pediatrics Web site.
- Screening for obesity in children and adolescents: clinical summary of U.S. Preventive Services Task Force recommendation. AHRQ Publication No. 10-05144-EF-3. Rockville, Maryland: Agency for Healthcare Research and Quality; 2010 Jan. Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site.

Background Articles:

- Barton M et al. How to read the new recommendation statement: methods update from the U.S. Preventive Services Task Force. Ann Intern Med. 2007;147:123-7. [8 references]
- Guirguis-Blake J et al. Current processes of the U.S. Preventive Services Task Force: refining evidence-based recommendation development. Ann Intern Med. 2007;147:117-122. [4 references]
- Sawaya GF et al. Update on the methods of the U.S. Preventive Services Task Force: estimating certainty and magnitude of net benefit. Ann Intern Med. 2007;147:871-875. [5 references]

Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site.

The following is also available:

- The guide to clinical preventive services, 2009. Recommendations of the U.S. Preventive Services Task Force. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ), 2009. 265 p. Electronic copies available from the AHRQ Web site.

Print copies: Available from the Agency for Healthcare Research and Quality Publications Clearinghouse. For more information, go to http://www.ahrq.gov/news/pubsix.htm or call 1-800-358-9295 (U.S. only).

The Electronic Preventive Services Selector (ePSS), available as a PDA application and a web-based tool, is a quick hands-on tool designed to help primary care clinicians identify the screening, counseling, and preventive medication services that are appropriate for their patients. It is based on current recommendations of the USPSTF and can be searched by specific patient characteristics such as age, sex, and selected behavioral risk factors.

PATIENT RESOURCES

The following are available:

- Men: stay healthy at any age. Your checklist for health. Rockville (MD): Agency for Healthcare Research and Quality. 2007 Feb. Electronic copies: Available from the USPSTF Web site. See the related QualityTool summary on the Health Care Innovations Exchange Web site.
- Women: stay healthy at any age. Your checklist for health. Rockville (MD): Agency for Healthcare Research and Quality. 2007 Feb. Electronic copies: Available from the USPSTF Web site. See the related QualityTool summary on the Health Care Innovations Exchange Web site.

Print copies: Available in English and Spanish from the Agency for Healthcare Research and Quality Publications Clearinghouse. For more information, go to http://www.ahrq.gov/news/pubsix.htm or call 1-800-358-9295 (U.S. only).

Myhealthfinder is a new tool that provides personalized recommendations for clinical preventive services specific to the user's age, gender, and pregnancy status. It features evidence-based recommendations from the USPSTF and is available at www.healthfinder.gov.

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC STATUS

This NGC summary was completed by ECRI on June 24, 2005. The information was verified by the guideline developer on June 30, 2005. This NGC summary was

updated by ECRI Institute on March 4, 2010. The updated information was verified by the guideline developer on March 29, 2010.

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Date Modified: 4/19/2010


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